OBSTETRICS & GYNECOLOGY

NOTICE: This document contains correspondence generated during peer review and subsequent revisions but before transmittal to production for composition and copyediting:

- Comments from the reviewers and editors (email to author requesting revisions)
- Response from the author (cover letter submitted with revised manuscript)*

**The corresponding author has opted to make this information publicly available.*

Personal or nonessential information may be redacted at the editor's discretion.

Questions about these materials may be directed to the *Obstetrics & Gynecology* editorial office: obgyn@greenjournal.org.

Date: May 08, 2020
To: "Christina S Han" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-20-1082

RE: Manuscript Number ONG-20-1082

Practice Modification for Pandemics: A Model for Surge Planning in Obstetrics

Dear Dr. Han:

Your manuscript has been reviewed by the Editorial Board and by special expert referees. The Editors is interested in potentially publishing your revised manuscript in a timely manner. In order to have this considered quickly, we need to have your revision documents submitted to us as soon as you are able. I am tentatively setting your due date to May 15, 2020, but please let me know if you need additional time.

The standard revision letter text follows.

If you wish to consider revising your manuscript, you will first need to study carefully the enclosed reports submitted by the referees and editors. Each point raised requires a response, by either revising your manuscript or making a clear and convincing argument as to why no revision is needed. To facilitate our review, we prefer that the cover letter include the comments made by the reviewers and the editor followed by your response. The revised manuscript should indicate the position of all changes made. We suggest that you use the "track changes" feature in your word processing software to do so (rather than strikethrough or underline formatting).

REVIEWER COMMENTS:

Reviewer #1: The purpose of this manuscript is to discuss "proposed pandemic-adjusted modifications in obstetrical care, with discussion of risks and benefits based on available evidence. We suggest best practices for balancing community mitigation efforts with appropriate care of obstetrical patients to avoid unintended adverse sequelae." This is a Clinical Expert Series.

1. In Postpartum Care can the author expand discussion of breast feeding during the pandemic? Rooming-in of the infant? Infant in the nursery?

2. The authors discuss early discharge of the maternal-infant dyad. How does newborn screening fit with early discharge and timing? As the authors note discharge <24-30 hours is associated with increased neonatal admission.

3. Is there any change in Genetic Counselling during the pandemic? Any change in offering Genetic screening and diagnostic tests during the pandemic? What is the role of NIPT during the pandemic, especially for AMA?

4. Could the authors expand their discussion to include some of the ethical issues and planning related to the triage process, especially at higher triage levels (when the hospitals are full to capacity and no ventilators)?

5. Line 44: "Obstetrics and Gynecologists". Should this be Obstetricians and Gynecologists?

6. LIne 104-105: "or loss of normal ultrasound finding progression on transvaginal imaging. (17,18)" Please re-write this portion of the sentence.

7. Under Early pregnancy loss: do the authors want to add anything about management of patients with Recurrent pregnancy loss?

8. Line 273: "or AC or EFW". Please spell out AC.

9. Lines 344-346: Please re-write the following sentence: "While patients with poorly controlled GDM may benefit from a 37 0/7-386/7 week delivery to avoid stillbirth, not requiring medical management and with unfavorable cervix may be best served by expectant management up to 41 weeks. (66,71)."

10. Lines 377-381: Please re-write this sentence. "When there is concern for potential aerosolizing intubation of an asymptomatic infected patient based on regional epidemiology and rapid testing resources are available, there should be

either consideration of universal infectious testing on Labor and Delivery, or early provision of regional anesthesia to patients who have evidence of stalled labor or non-reassuring features on fetal cardiotocography."

11. Lines 525-527: " including lower income jobs, and employment within the service industry (such as food service, grocery stores, transportation) with higher rates of direct public contact and risk for infection during pandemics. (121)" Are these also the jobs with higher rates of unemployment due to the pandemic?

12. The authors use LGBTQI and LGBTQ abbrevations. Please use same abbreviation through manuscript.

13. In table 2. Should symptoms also include abdominal pelvic pain?

14. In Table 3: Antenatal steroids, under pandemic-adjusted recommendations: please re-write "magnesium antenatal corticosteroids".

15. In table 3: Tranexamic acid, under pandemic-adjusted recommenation: How about during the COVID-19 pandemic? Has COVID-19 been associated with prothrombotic state during pregnancy or postpartum state?

16. In Table 5: under additional precautions: "Decrease risk of emergent conversion to cesarean due to potential need for intubation, viral aersolization during pandemics, and time needed for donning and doffing personal protective equipment." How does one Decrease risk?

Reviewer #2:

This review of modifications of obstetric care in the time of a pandemic is well written, comprehensive and well thought out. I believe strongly that this should not wait to be published in the normal fashion. This document is needed NOW. If accepted I think the Journal should send out to all obstetrical providers in a special email.

My only comments are:

1. There is no section on Pregestational Diabetes- I think this should be added

2. Table 3 under steroids has information about magnesium sulfate. I think this should be in the box labeled magnesium sulfate

3. There is no discussion about the possibility of implementing these changes in care could result in maternal, neonatal or fetal adverse outcomes and if adoption of these changes in care as proposed by ACOG can be considered as "Standard of Care" if obstetrical providers were to be accused of malpractice by changing how obstetrical care was provided resulted in an adverse outcome.

4. There could be a follow up to ask the question "if these modifications of Ob care are considered as appropriate, why are they not appropriate when there is no resource limitation imposed by a pandemic". Could these be the new standard of providing Obstetrical care.

Reviewer #3: The authors present a very well-researched comprehensive plan for obstetrical care during the pandemic and should be congratulated. Below, I offer some minor editing suggestions. The only aspect actually missing from the manuscript is an emphasis on the increased importance of patient education and true partnering with our patients during this paradigm shift of decreased and remote patient care.

1. Line 109: consider adding 'symptomatic' after 'at-risk'

2. Line 113: consider changing 'can be considered' to 'should be considered'

3. Lines 102-117: consider adding a component of patient counseling about bleeding precautions and when to seek emergent care. Many women are confused or scared about when/if to present to the ER during the crisis.

4. Line 161: change 'is' to 'are' (the word data is plural).

5. Line 216-224: as with early pregnancy loss, consider adding a component of patient education. Unfortunately, home BP monitoring is not possible for all patients, and as such, education regarding symptoms of preE is crucial.

6. Line 273: spell out AC if this is the first time using.

7. Line 289: add 'the' before US.

8. Line 295: awkward grammar; consider changing 'in particular as' to 'especially because'.

9. Lines 321-325: this may actually increase hospitalization duration; it seems to this reviewer that the well selected patient for outpatient management of PPROM is few and far between, and as such, most will remain in-house. While the data are there, this may not be the time to suggest such a change in standard of care practice.

10. Line 338: as a provider of group prenatal care for women with GDM, I'm confused why telemedicine lends itself well to institutions providing group care. Remove or clarify.

11. Line 345: add 'those' before 'not requiring medical management'

12. Antepartum care: given the authors brought it up with GDM … you may consider adding a blurb about group prenatal care during the surge. Most institutions have deemed it unsafe and not feasible, but it might be worth putting that in print, and suggesting alternatives.

13. Line 471: is that only low-income women prefer contraception prior to discharge, or most institutions currently only offer it to low-income patients via Medicaid? I would strongly suggest removing the words 'low-income'.

14. Lines 467-488: This section could be renamed LARC rather than contraception. Please include thoughts about how best to facilitate our patients receiving other methods of contraception; e.g. maybe this is the window of opportunity to advocate for over the counter contraception, DepoProvera prior to discharge, telehealth for OCPs without a requirement for annual exams?? Additionally, as the authors know, inpatient postpartum LARC can be very difficult for some institutions. Simply 'encouraging' inpatient PP LARC is not an acceptable solution for institutions where this was not in place prior to the pandemic.

15. Lines 520-41: thank you!! I had a note to myself while reading through the entire article that this was missing. Telehealth is just not the answer for many of our patients.

16. Table 1, top box: 'medication history' is repeated

17. Table 2, under 'Historical factors': cesarean is not usually capitalized (under 'higher order') and consider removing 'advanced' before maternal age (since the line also includes young women).

18. Table 5, page 58, 'Management' third box: there is an extra bullet point

19. Table 5, page 60, GDM: most would disagree that group prenatal care is acceptable during social distancing. The authors are recommending it during the surge?

20. Table 5, page 60, GDM as well as in manuscript: may consider adding a suggestion for screening for type 2 DM during the inpatient delivery stay (Waters et al, AJOG Jan 2020), or screening with a HgA1c if an in-person visit is possible 6-12 weeks PP (to decrease in office time required for a 2 hour GTT). Although the data are clearly mixed, these might be acceptable options during the pandemic.

MANUSCRIPT EDITOR'S COMMENTS:

1. ACOG is moving toward discontinuing the use of “provider.” Please replace “provider” throughout your paper with either a specific term that defines the group to which are referring (for example, “physicians,” “nurses,” etc.), or use “health care professional” if a specific term is not applicable.

2. Expand the abbreviation "EDD" to read, "estimated due date."

3. Expand the abbreviation "CSP" to read, "cesarean scar pregnancy."

4. Expand the abbreviation "AMA" to read, "advanced maternal age."

5. The journal does not use the abbreviation "PPROM." Expand it to read, "preterm prelabor rupture of membranes (PROM)" at first mention. After that, use "preterm PROM."

6. The subheading "Gestational Diabetes" should read, "Gestational Diabetes Mellitus." In the next line of text, change "GDM" to read, "gestational diabetes mellitus (GDM)." It's okay to use the abbreviation thereafter.

7. Expand the abbreviation "DSME" for "diabetic self-management education."

8. Expand the abbreviation "PPH" for "postpartum hemorrhage."

9. Expand the abbreviation "PPBTL" for "postpartum tubal ligation."

10. Expand the abbreviation "PPMD" for "postpartum mood disorders."

11. Reference 22 is not the current document for tubal ectopic pregnancy. Please review Practice Bulletin No. 193 at https://www.acog.org/clinical/clinical-guidance/practice-bulletin to make sure it supports what you are saying. If it does, your reference should be updated to read the following:
Tubal ectopic pregnancy. ACOG Practice Bulletin No. 193. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;131:e91:103.

12. Reference 49 is not the current document for acute-onset, severe hypertension during pregnancy. Please review Committee Opinion No. 767 https://www.acog.org/clinical/clinical-guidance/practice-bulletin to make sure it supports what you are saying. If it does, your reference should be updated to read the following:
Emergent therapy for acute-onset, severe hypertension during pregnancy and the postpartum period. ACOG Committee Opinion No. 767. American College of Obstetricians and Gynecologists. Obstet Gynecol 2019;133:e174-80.

13. Please add more detail to reference 74 (authors, journal name, URL, etc.).

14. Please provide a copy of your source for Table 1 (the pages you used from the document). Note that the journal does not seek permission for modifications of material. We will reprint the information exactly as it was published.

15. What is the source of Tables 2, 3, and 5?

16. Table 4 cites Committee Opinion No. 736. Would you describe what sections of the Committee Opinion you used to create the Table?

EDITOR'S COMMENTS

Please emphasize that this is all opinion base with no information about outcomes of these alterations in our typical care so we don't really know the risk/benefit of these changes. We know the benefit to the health care workers and the patients in terms of cross-contamination, but nothing about the risks of these changes. There may, of course, be none.

Please also address prenatal education (childbirth education, preparation for parenting, breastfeeding preparation, etc). You of course can't address everything and each reviewer has added stuff to consider. However, I've always considered prenatal care (just as with post natal care) as much about the transition to mothering, agency of the patient and understanding what is happening to her body.

EDITORIAL OFFICE COMMENTS:

1. The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:
A. OPT-IN: Yes, please publish my point-by-point response letter.
B. OPT-OUT: No, please do not publish my point-by-point response letter.

2. Obstetrics & Gynecology uses an "electronic Copyright Transfer Agreement" (eCTA). When you are ready to revise your manuscript, you will be prompted in Editorial Manager (EM) to click on "Revise Submission." Doing so will launch the resubmission process, and you will be walked through the various questions that comprise the eCTA. Each of your coauthors will receive an email from the system requesting that they review and electronically sign the eCTA.

Please check with your coauthors to confirm that the disclosures listed in their eCTA forms are correctly disclosed on the manuscript's title page.

3. Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology has adopted the use of the reVITALize definitions. Please access the obstetric and

gynecology data definitions at https://www.acog.org/About-ACOG/ACOG-Departments/Patient-Safety-and-Quality-Improvement/reVITALize. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

4. Provide a short title of no more than 45 characters, including spaces, for use as a running foot.

5. The most common deficiency in revised manuscripts involves the abstract. Be sure there are no inconsistencies between the Abstract and the manuscript, and that the Abstract has a clear conclusion statement based on the results found in the paper. Make sure that the abstract does not contain information that does not appear in the body text. If you submit a revision, please check the abstract carefully.

In addition, the abstract length should follow journal guidelines. The word limit for Clinical Expert Series articles is 250 words. Please provide a word count.

6. Only standard abbreviations and acronyms are allowed. A selected list is available online at http://edmgr.ovid.com/ong/accounts/abbreviations.pdf. Abbreviations and acronyms cannot be used in the title or précis. Abbreviations and acronyms must be spelled out the first time they are used in the abstract and again in the body of the manuscript.

7. The journal does not use the virgule symbol (/) in sentences with words. Please rephrase your text to avoid using "and/or," or similar constructions throughout the text. You may retain this symbol if you are using it to express data or a measurement.

8. ACOG is moving toward discontinuing the use of "provider." Please replace "provider" throughout your paper with either a specific term that defines the group to which are referring (for example, "physicians," "nurses," etc.), or use "health care professional" if a specific term is not applicable.

9. Please standardize the presentation of your data throughout the manuscript submission. For P values, do not exceed three decimal places (for example, "P = .001"). For percentages, do not exceed one decimal place (for example, 11.1%").

10. Please review the journal's Table Checklist to make sure that your tables conform to journal style. The Table Checklist is available online here: http://edmgr.ovid.com/ong/accounts/table_checklist.pdf.

11. The American College of Obstetricians and Gynecologists' (ACOG) documents are frequently updated. These documents may be withdrawn and replaced with newer, revised versions. If you cite ACOG documents in your manuscript, be sure the reference you are citing is still current and available. If the reference you are citing has been updated (ie, replaced by a newer version), please ensure that the new version supports whatever statement you are making in your manuscript and then update your reference list accordingly (exceptions could include manuscripts that address items of historical interest). If the reference you are citing has been withdrawn with no clear replacement, please contact the editorial office for assistance (obgyn@greenjournal.org). In most cases, if an ACOG document has been withdrawn, it should not be referenced in your manuscript (exceptions could include manuscripts that address items of historical interest). All ACOG documents (eg, Committee Opinions and Practice Bulletins) may be found at the Clinical Guidance page at https://www.acog.org/clinical (click on "Clinical Guidance" at the top).

12. Authors whose manuscripts have been accepted for publication have the option to pay an article processing charge and publish open access. With this choice, articles are made freely available online immediately upon publication. An information sheet is available at http://links.lww.com/LWW-ES/A48. The cost for publishing an article as open access can be found at http://edmgr.ovid.com/acd/accounts/ifauth.htm.

Please note that if your article is accepted, you will receive an email from the editorial office asking you to choose a publication route (traditional or open access). Please keep an eye out for that future email and be sure to respond to it promptly.

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If you choose to revise your manuscript, please submit your revision through Editorial Manager at http://ong.editorialmanager.com. Your manuscript should be uploaded in a word processing format such as Microsoft Word. Your revision's cover letter should include the following:

* A confirmation that you have read the Instructions for Authors (http://edmgr.ovid.com/ong/accounts/authors.pdf), and
* A point-by-point response to each of the received comments in this letter.

If you submit a revision, we will assume that it has been developed in consultation with your co-authors and that each author has given approval to the final form of the revision.

Again, your paper will be maintained in active status for 30 days from the date of this letter. If we have not heard from you by May 15, 2020, we will assume you wish to withdraw the manuscript from further consideration..

Sincerely,

Dwight J. Rouse, MD
Associate Editor for Obstetrics

2018 IMPACT FACTOR: 4.965
2018 IMPACT FACTOR RANKING: 7th out of 83 ob/gyn journals

_____

[redacted]

April 28th, 2020

Nancy Chescheir, MD
Dwight Rouse, MD
Obstetrics and Gynecology

Dear Drs. Chescheir and Rouse:

Please find enclosed the revision of our manuscript entitled "Practice Modification for Pandemics: A Model for Surge Planning in Obstetrics."

We thank the reviewers for the thoughtful recommendations. We have worked together to address your concerns. Please see specifically addressed comments to each suggestion below. The line numbers listed are from the version of the document without tracked changes, although the tracked changes version is also included.

Reviewer #1:

1. In Postpartum Care can the author expand discussion of breast feeding during the pandemic? Rooming-in of the infant? Infant in the nursery?
We have added a section on immediate postpartum care with a focus on rooming-in, breastfeeding, and shared decision-making for the mother-infant dyad. (Lines 469-476)

2. The authors discuss early discharge of the maternal-infant dyad. How does newborn screening fit with early discharge and timing? As the authors note discharge <24-30 hours is associated with increased neonatal admission.
The section on neonatal discharge timing has been reworded and addressed in lines 477-483.

3. Is there any change in Genetic Counseling during the pandemic? Any change in offering Genetic screening and diagnostic tests during the pandemic? What is the role of NIPT during the pandemic, especially for AMA?
A discussion on genetic counseling has been added in lines 101-108. This information was also included in the table.

4. Could the authors expand their discussion to include some of the ethical issues and planning related to the triage process, especially at higher triage levels (when the hospitals are full to capacity and no ventilators)?
A section on general ethics of resource triage has been added in lines 424-432.

5. Line 44: "Obstetrics and Gynecologists". Should this be Obstetricians and Gynecologists?
Thank you for noting this error. This has been corrected in Line 45.

6. LIne 104-105: "or loss of normal ultrasound finding progression on transvaginal imaging. (17,18)" Please re-write this portion of the sentence.

This portion of the sentence has been reworded in line 111-113.

7. Under Early pregnancy loss: do the authors want to add anything about management of patients with Recurrent pregnancy loss?
A line on recurrent pregnancy has been added in line 119-120.

8. Line 273: "or AC or EFW". Please spell out AC.
Thank you for noting this error. This has been corrected in Line 288.

9. Lines 344-346: Please re-write the following sentence: "While patients with poorly controlled GDM may benefit from a 37 0/7-386/7 week delivery to avoid stillbirth, not requiring medical management and with unfavorable cervix may be best served by expectant management up to 41 weeks. (66,71)."
This portion of the sentence has been corrected in lines 364-366.

10. Lines 377-381: Please re-write this sentence. "When there is concern for potential aerosolizing intubation of an asymptomatic infected patient based on regional epidemiology and rapid testing resources are available, there should be either consideration of universal infectious testing on Labor and Delivery, or early provision of regional anesthesia to patients who have evidence of stalled labor or non-reassuring features on fetal cardiotocography."
This sentence has been reworded. (Line 397-399)

11. Lines 525-527: " including lower income jobs, and employment within the service industry (such as food service, grocery stores, transportation) with higher rates of direct public contact and risk for infection during pandemics. (121)" Are these also the jobs with higher rates of unemployment due to the pandemic?
Thank you for noting that these jobs are also those at the most risk. This point has been added in Lines 551-555. Additional references have been added to clarify this as well.

12. The authors use LGBTQI and LGBTQ abbreviations. Please use same abbreviation through manuscript.
LGBTQ *has been consistently used throughout the text.*

13. In table 2. Should symptoms also include abdominal pelvic pain?
This symptom has been added in Table 2.

14. In Table 3: Antenatal steroids, under pandemic-adjusted recommendations: please re-write "magnesium antenatal corticosteroids".
Thank you for noting this error. This has been corrected in Table 3.

15. In table 3: Tranexamic acid, under pandemic-adjusted recommendation: How about during the COVID-19 pandemic? Has COVID-19 been associated with prothrombotic state during pregnancy or postpartum state?
The discussion on tranexamic acid has been expanded in Table 3.

16. In Table 5: under additional precautions: "Decrease risk of emergent conversion to cesarean due to potential need for intubation, viral aerosolization during pandemics, and time needed for donning and doffing personal protective equipment." How does one Decrease risk?
We have clarified the recommendation on lowering threshold for cesarean delivery if non-reassuring fetal status is noted. This is now included in Table 3.

Reviewer #2:

This review of modifications of obstetric care in the time of a pandemic is well written, comprehensive and well thought out. I believe strongly that this should not wait to be published in the normal fashion. This document is needed NOW. If accepted I think the Journal should send out to all obstetrical providers in a special email.

Thank you for this thoughtful commentary on our work.

1. There is no section on Pregestational Diabetes- I think this should be added
The pregestational diabetes section was added back to the text in lines 831. It was initially cut for space concerns.

2. Table 3 under steroids has information about magnesium sulfate. I think this should be in the box labeled magnesium sulfate
Thank you for noting this error. This has been corrected in Table 3.

3. There is no discussion about the possibility of implementing these changes in care could result in maternal, neonatal or fetal adverse outcomes and if adoption of these changes in care as proposed by ACOG can be considered as "Standard of Care" if obstetrical providers were to be accused of malpractice by changing how obstetrical care was provided resulted in an adverse outcome.
Thank you for your comment. A comment as been added to the introduction (Lines 51-53) clarifying that these are opinions based on limited data, and therefore, may not be necessarily be in line with other society recommendations.

Furthermore, we have added a line regarding a call to action for further research on these modifications.(lines 622-624)

Reviewer #3:

The authors present a very well-researched comprehensive plan for obstetrical care during the pandemic and should be congratulated. Below, I offer some minor editing suggestions. The only aspect actually missing from the manuscript is an emphasis on the increased importance of patient education and true partnering with our patients during this paradigm shift of decreased and remote patient care.

Thank you for the support, and for suggesting this important point on patient education. We have added education and shared decision-making throughout the text, in lines 217, 244, 257, 329, 474, 487, and 614.

1. Line 109: consider adding 'symptomatic' after 'at-risk'
This has been corrected, now located in line 117.

2. Line 113: consider changing 'can be considered' to 'should be considered'
This has been corrected, now located in line 122.

3. Lines 102-117: consider adding a component of patient counseling about bleeding precautions and when to seek emergent care. Many women are confused or scared about when/if to present to the ER during the crisis.
This has been corrected, now located in line 126-127.

4. Line 161: change 'is' to 'are' (the word data is plural).
Thank you for noting this error. This has been corrected, now located in line 171.

5. Line 216-224: as with early pregnancy loss, consider adding a component of patient education. Unfortunately, home BP monitoring is not possible for all patients, and as such, education regarding symptoms of preE is crucial.
Thank you for noting this important distinction. This has been corrected in Line 243-244.

6. Line 273: spell out AC if this is the first time using.
Thank you for noting this error. This has been corrected, now located in line 288.

7. Line 289: add 'the' before US.
The line containing US was removed during the editing process to comply with word counts..

8. Line 295: awkward grammar; consider changing 'in particular as' to 'especially because'.
All instances of "in particular as" were removed.

9. Lines 321-325: this may actually increase hospitalization duration; it seems to this reviewer that the well selected patient for outpatient management of PPROM is few and far between, and as such, most will remain in-house. While the data are there, this may not be the time to suggest such a change in standard of care practice.
Thank you for noting this concern. We have changed this sentence: "Appropriate candidates whose pregnancy extends beyond this window can be evaluated for outpatient management. Prior to attempting an outpatient management protocol, patients must be carefully counseled regarding potential risks, informed that this is a management algorithm that is only offered during extenuating circumstances, and shared decision-making must be applied." (Lines 325-329) We anticipate that this will help our readers understand that caution must be taken if outpatient management is attempted.

10. Line 338: as a provider of group prenatal care for women with GDM, I'm confused why telemedicine lends itself well to institutions providing group care. Remove or clarify.
Thank you for noting this overstatement. We have separated the diabetes self-management and the group prenatal care into two separate statements for clarification. (Lines 355-359).

11. Line 345: add 'those' before 'not requiring medical management'
This has been corrected in line 365.

12. Antepartum care: given the authors brought it up with GDM … you may consider adding a blurb about group prenatal care during the surge. Most institutions have deemed it unsafe and not feasible, but it might be worth putting that in print, and suggesting alternatives.
Thank you for noting this point of clarification. We have edited this section to specify that group prenatal care should not be held in person. (Lines 355-359).

13. Line 471: is that only low-income women prefer contraception prior to discharge, or most institutions currently only offer it to low-income patients via Medicaid? I would strongly suggest removing the words 'low-income'.
This has been corrected. The terminology was that used in the original research articles, but this has been adjusted. Please see lines 498-500.

14. Lines 467-488: This section could be renamed LARC rather than contraception. Please include thoughts about how best to facilitate our patients receiving other methods of contraception; e.g. maybe this is the window of opportunity to advocate for over the counter contraception, DepoProvera prior to discharge, telehealth for OCPs without a requirement for annual exams?? Additionally, as the authors know, inpatient postpartum LARC can be very difficult for some institutions. Simply 'encouraging' inpatient PP LARC is not an acceptable solution for institutions where this was not in place prior to the pandemic.
This has been corrected and expanded to include the provision of other types of contraception, as well as other methods of "quick start" after delivery for these options. Please see lines 496-520.

15. Lines 520-41: thank you!! I had a note to myself while reading through the entire article that this was missing. Telehealth is just not the answer for many of our patients.
Thank you for this kind comment.

16. Table 1, top box: 'medication history' is repeated
Thank you for noting this error. This has been corrected.

17. Table 2, under 'Historical factors': cesarean is not usually capitalized (under 'higher order') and consider removing 'advanced' before maternal age (since the line also includes young women).
Thank you for noting this error. This has been corrected.

18. Table 5, page 58, 'Management' third box: there is an extra bullet point
Thank you for noting this error. This has been corrected.

19. Table 5, page 60, GDM: most would disagree that group prenatal care is acceptable during social distancing. The authors are recommending it during the surge?
Thank you (along with reviewer 2) for pointing out this area of confusion. We have corrected this section to specify that group prenatal care can be attempted via tele-conferencing, but that in-person group prenatal care should not be held.

20. Table 5, page 60, GDM as well as in manuscript: may consider adding a suggestion for screening

for type 2 DM during the inpatient delivery stay (Waters et al, AJOG Jan 2020), or screening with a HgA1c if an in-person visit is possible 6-12 weeks PP (to decrease in office time required for a 2 hour GTT). Although the data are clearly mixed, these might be acceptable options during the pandemic.
Thank you for this excellent suggestion. We've added GDM testing into both Tables 4 and 5.

MANUSCRIPT EDITOR'S COMMENTS:

1. ACOG is moving toward discontinuing the use of "provider." Please replace "provider" throughout your paper with either a specific term that defines the group to which are referring (for example, "physicians," "nurses," etc.), or use "health care professional" if a specific term is not applicable.
This has been corrected throughout the document

2. Expand the abbreviation "EDD" to read, "estimated due date."
This has been corrected.

3. Expand the abbreviation "CSP" to read, "cesarean scar pregnancy."
This has been corrected.

4. Expand the abbreviation "AMA" to read, "advanced maternal age."
This has been corrected.

5. The journal does not use the abbreviation "PPROM." Expand it to read, "preterm prelabor rupture of membranes (PROM)" at first mention. After that, use "preterm PROM."
This has been corrected.

6. The subheading "Gestational Diabetes" should read, "Gestational Diabetes Mellitus." In the next line of text, change "GDM" to read, "gestational diabetes mellitus (GDM)." It's okay to use the abbreviation thereafter.
This has been corrected.

7. Expand the abbreviation "DSME" for "diabetic self-management education."
This has been corrected.

8. Expand the abbreviation "PPH" for "postpartum hemorrhage."
This has been corrected.

9. Expand the abbreviation "PPBTL" for "postpartum tubal ligation."
This has been corrected.

10. Expand the abbreviation "PPMD" for "postpartum mood disorders."
This has been corrected.

11. Reference 22 is not the current document for tubal ectopic pregnancy. Please review Practice Bulletin No. 193 at https://www.acog.org/clinical/clinical-guidance/practice-bulletin to make sure it supports what you are saying. If it does, your reference should be updated to read the following:
Tubal ectopic pregnancy. ACOG Practice Bulletin No. 193. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;131:e91:103.
The reference has been updated and all data corrected to match the current document.

12. Reference 49 is not the current document for acute-onset, severe hypertension during pregnancy. Please review Committee Opinion No. 767 https://www.acog.org/clinical/clinical-guidance/practice-bulletin to make sure it supports what you are saying. If it does, your reference should be updated to read the following:
Emergent therapy for acute-onset, severe hypertension during pregnancy and the postpartum period. ACOG Committee Opinion No. 767. American College of Obstetricians and Gynecologists. Obstet Gynecol 2019;133:e174-80.
The reference has been updated and all data corrected to match the current document.

13. Please add more detail to reference 74 (authors, journal name, URL, etc.).
The reference has been updated

14. Please provide a copy of your source for Table 1 (the pages you used from the document). Note that the journal does not seek permission for modifications of material. We will reprint the information exactly as it was published.
Pages 151-152 have been noted for Table 1. Please let us know if the page numbers should be displayed in a different location in the paper.

15. What is the source of Tables 2, 3, and 5?

- *References have been added for Table 2.*
- *Tables 3 and 5 have references listed within each section. For example, "**Early pregnancy care** (6,7,11,13-14, 35-36)". These references can be moved elsewhere if necessary.*

16. Table 4 cites Committee Opinion No. 736. Would you describe what sections of the Committee Opinion you used to create the Table?
This was modified from Box 1 of CO #736.

ADDITIONAL NOTES FROM AUTHORS

We have taken this opportunity to include these two new references just released by SMFM:

1. Miller R, Timor-Tritsch IE, and Gyamfi-Bannerman C. Consult Series #49: Cesarean scar pregnancy. Society for Maternal-Fetal Medicine (SMFM). Am J Obstet Gynecol. 2020 May;222(5):B2-B14. doi: 10.1016/j.ajog.2020.01.030. Epub 2020 Jan 21.
2. Gevaerd Martins J, Biggio JR, Abuhmad A. Consult Series #52: Diagnosis and 2 Management of Fetal Growth Restriction. Society for Maternal Fetal Medicine. Accessed on smfm.org on May 12, 2020.

We have also edited the section on arm versus wrist cuffs using the most recent guidance from American Heart Association, and included these references:

1. Muntner P, Shimbo D, Carey RM, Charleston JB, Gaillard T, Misra S, Myers MG, Ogedegbe G, Schwartz JE, Townsend RR, Urbina EM, Viera AJ, White WB, Wright JT Jr. Measurement of Blood Pressure in Humans: A Scientific Statement From the American Heart Association. Hypertension. 2019 May;73(5):e35-e66.
2. Barton JR, Saade GR, **Sibai** BM. A Proposed Plan for Prenatal Care to Minimize Risks of COVID-19 to Patients and Providers: Focus on Hypertensive Disorders of Pregnancy. Am J Perinatol. 2020 May 12. Epub 2020 May 12.

EDITOR'S COMMENTS:

Please emphasize that this is all opinion base with no information about outcomes of these alterations in our typical care so we don't really know the risk/benefit of these changes. We know the benefit to the health care workers and the patients in terms of cross-contamination, but nothing about the risks of these changes. There may, of course, be none.
Thank you for this comment. We have added a comment to both the beginning and end of the manuscript to this regard. We've also made a call to increase research on these modified algorithms.

Please also address prenatal education (childbirth education, preparation for parenting, breastfeeding preparation, etc). You of course can't address everything and each reviewer has added stuff to consider. However, I've always considered prenatal care (just as with post natal care) as much about the transition to mothering, agency of the patient and understanding what is happening to her body.

We agree that these are important portions of the prenatal process. We have added comments about the value and need to provide this education even during the time of adjusted schedules.

EDITORIAL OFFICE COMMENTS:

1. The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:

OPT-IN: Yes, please publish my point-by-point response letter.

2. Obstetrics & Gynecology uses an "electronic Copyright Transfer Agreement" (eCTA). When you are ready to revise your manuscript, you will be prompted in Editorial Manager (EM) to click on "Revise Submission." Doing so will launch the resubmission process, and you will be walked through the various questions that comprise the eCTA. Each of your coauthors will receive an email from the system requesting that they review and electronically sign the eCTA.

Please check with your coauthors to confirm that the disclosures listed in their eCTA forms are correctly disclosed on the manuscript's title page.

All disclosures listed are correct and current.

3. Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology has adopted the use of the reVITALize definitions. Please access the obstetric and gynecology data definitions at https://www.acog.org/About-ACOG/ACOG-Departments/Patient-Safety-and-Quality-Improvement/reVITALize. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

All definitions comply with the revitalize initiative. Of note, due to the website overhaul, the URL has moved to: https://www.acog.org/practice-management/health-it-and-clinical-informatics/revitalize-obstetrics-data-definitions

4. Provide a short title of no more than 45 characters, including spaces, for use as a running foot.

We suggest: ***"Obstetric Practice Modification for Pandemics"***

5. The most common deficiency in revised manuscripts involves the abstract. Be sure there are no inconsistencies between the Abstract and the manuscript, and that the Abstract has a clear conclusion statement based on the results found in the paper. Make sure that the abstract does not contain information that does not appear in the body text. If you submit a revision, please check the abstract carefully.

In addition, the abstract length should follow journal guidelines. The word limit for Clinical Expert Series articles is 250 words. Please provide a word count.

The word count for the abstract is 50.

6. Only standard abbreviations and acronyms are allowed. A selected list is available online at

http://edmgr.ovid.com/ong/accounts/abbreviations.pdf. Abbreviations and acronyms cannot be used in the title or précis. Abbreviations and acronyms must be spelled out the first time they are used in the abstract and again in the body of the manuscript.

We have ensured that abbreviations are in compliance with protocols.

7. The journal does not use the virgule symbol (/) in sentences with words. Please rephrase your text to avoid using "and/or," or similar constructions throughout the text. You may retain this symbol if you are using it to express data or a measurement.

We have removed the virgule symbol.

8. ACOG is moving toward discontinuing the use of "provider." Please replace "provider" throughout your paper with either a specific term that defines the group to which are referring (for example, "physicians," "nurses," etc.), or use "health care professional" if a specific term is not applicable.
Thank you for this initiative. We have removed "provider" from the document.

9. Please standardize the presentation of your data throughout the manuscript submission. For P values, do not exceed three decimal places (for example, "P = .001"). For percentages, do not exceed one decimal place (for example, 11.1%").

We acknowledge this recommendation and have confirmed that presentation is standardized throughout the manuscript.

10. Please review the journal's Table Checklist to make sure that your tables conform to journal style. The Table Checklist is available online here: http://edmgr.ovid.com/ong/accounts/table_checklist.pdf.

We have edited the table to comply with the journal style.

11. The American College of Obstetricians and Gynecologists' (ACOG) documents are frequently updated. These documents may be withdrawn and replaced with newer, revised versions. If you cite ACOG documents in your manuscript, be sure the reference you are citing is still current and available. If the reference you are citing has been updated (ie, replaced by a newer version), please ensure that the new version supports whatever statement you are making in your manuscript and then update your reference list accordingly (exceptions could include manuscripts that address items of historical interest). If the reference you are citing has been withdrawn with no clear replacement, please contact the editorial office for assistance (obgyn@greenjournal.org). In most cases, if an ACOG document has been withdrawn, it should not be referenced in your manuscript (exceptions could include manuscripts that address items of historical interest). All ACOG documents (eg, Committee Opinions
and Practice Bulletins) may be found at the Clinical Guidance page at https://www.acog.org/clinical
(click on "Clinical Guidance" at the top).

Thank you for pointing out the reference errors above. These have been corrected.

Thank you again for your consideration.

Yours sincerely,

Christina S. Han, MD, *on behalf of all authors*

[redacted]